MILEAGE REIMBURSEMENT

Claim Number:_____
Employee: _____
Employer: _____
Date of Accident: _____

****PLEASE COMPLETE EACH SECTION OF THIS FORM FOR EACH DAY MILEAGE REIMBURSEMENT THAT IS BEING CLAIMED.**

NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY:	DATE(S)	ADDRESS CLAIMANT STARTED FROM	ADDRESS OF FINAL DESTINATION AFTER DR'S APPT	ROUND TRIP MILES

PLEASE DO NOT WRITE IN THIS SPACE

MILEAGE IS REIMBURSED AT $.445 CENTS PER MILE FOR TRAVEL TO/FROM AUTHORIZED MEDICAL PROVIDERS AFTER 6/30/06.

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, FS.

Mail to: Division of Risk Management
Workers' Compensation Section
P.O. Box 8020
Tallahassee, Florida 32314-8020

Claimant's Signature: _____

Date: _____

REV. 3/2010